

3517

03505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 64

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Caroline		STATE	Maryland COUNTY Caroline	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	FEDERALSBURG		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	FEDERALSBURG	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Brooklyn Avenue		STREET ADDRESS (If rural, give location)	Brooklyn Avenue	
3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
Thomas George Orem Chase				April 21	19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	Colored	Divorced	Sept. 22, 1917	37 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
Day Laborer	Shoe Repair Shop		Federalsburg, Maryland	U.S.A.	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
George W. Chase			Bertha Webb		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
No		Unknown	Bertha E. Prattis, Federalsburg, Maryland		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				?
Immediate cause (a) <u>Myocarditis</u> DUE TO Antecedent cause(s) (b) <u>Pulmonary Edema</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)				2 hr
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)		
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE <u>Dr. J. J. Frampton</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	April 24, 1955	Federal Hill Cemetery	Federalsburg, Maryland	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
April 23, 1955	Margaret H. Frampton	J. J. Frampton and Son, Federalsburg, Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 4 1955

RECEIVED

3518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethlehem</u>		LENGTH OF STAY (in this place) <u>8 Yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethlehem</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Richard Christopher</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 4 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>October 8, 1873</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bridge Tender-Talbot County</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Talbot County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME: <u>Isaiah Christopher</u>				14. MOTHER'S MAIDEN NAME: <u>Suda Hopkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Margaret Pizzi, Kirklyn, Penna.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						<u>3 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Coronary Artery Sclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Artery Sclerosis</u>						<u>20 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/26</u> , 19 <u>41</u> , to <u>4/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/4</u> , 19 <u>55</u> , and that death occurred at <u>8:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James B. Plummer</u>		M. D. <u>Preston Maryland</u>		DATE SIGNED <u>4/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Linchester Cemetery</u>		LOCATION (City, town, or county) (State) <u>Preston, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-5-55</u>		REGISTRAR'S SIGNATURE <u>Cornelia D. Plummer</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg</u>		ADDRESS	

BUREAU V. S.

APR 11 1955

RECEIVED

3519

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Greensboro</u>				STREET ADDRESS (If rural give location)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		None		None		/	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Emory Claude Conner				DATE OF DEATH: 4 4 55 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	Married	1/12/1894	61 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Retired Farm Owner			None		Maryland		U.S.A.
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Richard Conner				Cora Corkran			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Yes <input checked="" type="checkbox"/> W.W.1		194-22-7943		Helen Conner Greensboro, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
200.1 IMMEDIATE CAUSE (A) <u>Lymphosarcoma</u>							23 months.
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from Aug. 8, 1953, to April 4, 1955, that I last saw the deceased alive on April 3, 1955, and that death occurred at 2:25 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Stouffer</u>			ADDRESS <u>Greensboro Md</u>			DATE SIGNED <u>April 5 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4/6/55		Greensboro		Greensboro, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Apr 6-1955		<u>L. MacP...</u>		<u>J.E. Boula...</u>		<u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 11 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3520

03508

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. *62*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Denton - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pinetown</u>				STREET ADDRESS (If rural, give location) <u>Pinetown</u>			
3. NAME OF DECEASED: (First) <u>Edward</u>		(Middle) <u>William</u>		(Last) <u>Dickerson</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>October 15, 1900</u>		9. AGE last birthday: <u>54</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>No data available</u>				14. MOTHER'S MAIDEN NAME: <u>Alice Dickerson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>218-10-7398</u>		17. INFORMANT & ADDRESS: <u>Mary E. Thompson, Atlantic City, N. J.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH:	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>82-5X</u> Immediate cause (a) <u>Internal Injuries</u> DUE TO Antecedent cause(s) (b) <u>Crushed Chest</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>immediate</u> 14	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>Highway</u>		21c. (City or town) <u>Prank Denton Caroline</u> (County) <u>No</u> (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4 16-55 3:30 P.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Denton D. George</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-21-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>April 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Federalsburg, Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/21/55</u>		REGISTRAR'S SIGNATURE <u>Dr. D. George</u>		24. FUNERAL DIRECTOR ADDRESS <u>J. J. Frampton and Son, Federalsburg, Md.</u>			

RECEIVED

APR 26 1955

BUREAU V. S.

3521

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Caroline</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		LENGTH OF STAY (in this place) <i>2 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Denton, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural give location) <i>X</i>			
3. NAME OF DECEASED: (First) <i>Margaret</i> (Middle) <i>Newton</i> (Last) <i>Henderson</i>				4. DATE OF DEATH: (Month) <i>Apr.</i> (Day) <i>20</i> (Year) <i>1955</i>			
5. SEX: <i>7</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>		8. DATE OF BIRTH: <i>Jan. 29, 1874</i>	
				9. AGE last birthday: <i>81</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <i>Missionary</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Africa</i>		11. BIRTHPLACE (State or foreign country): <i>England</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME: <i>Thomas G. Newton</i>			
14. MOTHER'S MAIDEN NAME: <i>Frances Thomas</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS: <i>Mrs. E. Sutton Denton, Ind.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<i>422.2 Immediate cause</i>						<i>4 Mon</i>	
(a) <i>Myocarditis Chronic</i>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
(b) <i>Cerebral Hemorrhage</i>						<i>24m</i>	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan</i> , 1955, to <i>4-20</i> , 1955, that I last saw the deceased alive on <i>4-18</i> , 1955, and that death occurred at <i>4 AM</i> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <i>Lawson O. George M.D.</i>				DATE SIGNED <i>4-20-55</i>			
23. BURIAL, CREMATION, REMOVAL. (Specify) <i>Burial</i>		DATE THEREOF <i>Apr. 25, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>Hereford</i>		LOCATION (City, town, or county) (State) <i>Verford, Ind.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4-20-55</i>		REGISTRAR'S SIGNATURE <i>Dr. D. O. George</i>		24. FUNERAL DIRECTOR <i>Virgil Moore</i>		ADDRESS <i>Denton, Ind.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 26 1955

RECEIVED

3522

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) DR TOWN	
<u>X</u> <u>Greensboro</u>	<u>72 Yrs.</u>	<u>Greensboro</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>00</u> <u>None</u>		<u>None</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Mary</u>	(Middle) <u>Emily</u>	(Last) <u>Howard</u>	
(Type or Print)		OF DEATH: <u>4</u> <u>17</u> <u>55</u> <u>19</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>6/22/1882</u>
9. AGE last birthday:		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>72</u> yrs.		Months	Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life.)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Housewife</u>		<u>None</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Delaware</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Robert Hopkins</u>		<u>Louise Wyatt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>No</u>		<u>None</u>	
17. INFORMANT & ADDRESS:			
<u>Frank Howard Greensboro, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
170X IMMEDIATE CAUSE (A) <u>Adeno Carcinoma of Breast</u>		
ANTECEDENT CAUSE (B) <u>Generalized Metastases</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) <u>Type I Acute Cardiovascular Disease</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>1/7/53</u>	<u>Rt. Radical Mastectomy. Carcinoma of Breast</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
	INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>53</u> , to <u>Apr. 17</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Apr. 17</u> , 19 <u>55</u> , and that death occurred at <u>4:10 AM</u> , from the causes and on the date stated above.		
SIGNATURE <u>Charles H. Hines</u>		DATE SIGNED <u>Apr 18 1955</u>
ADDRESS <u>Greensboro</u>		
M. D. <u>Greensboro</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>	<u>4/20/55</u>	<u>Greensboro</u>
LOCATION (City, town, or county) (State)		
<u>Greensboro, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR
<u>Apr 20 - 1955</u>		ADDRESS
REGISTRAR'S SIGNATURE <u>L. M. Phipps</u>		<u>J. E. Boulaie Greensboro, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 25 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

03511

3523

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greensboro</u> LENGTH OF STAY (In this place) <u>79 Yrs.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Greensboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>Wilbert</u>		(Middle) <u>Mc Knatt</u>		(Last)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, <u>WIDOWED</u> DIVORCED, (Specify)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>8</u> (Year) <u>55</u> <u>19</u>	
8. DATE OF BIRTH <u>1/13/1876</u>		9. AGE last birthday <u>79</u> yrs.		If under 1 year Months <u> </u> Days <u> </u>		If under 24 hrs Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John McNatt</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Dill</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No. <u>218-20-4119</u>				17. INFORMANT AND ADDRESS <u>Laura Truitt Queen Anne, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1 Coronary occlusion</u>						<u>few minutes</u>	
Antecedent cause(s) (b) <u>Coronary sclerosis</u>						<u>?</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE <u>Lawson J. George MD</u>				ADDRESS <u>Deputy Medical Examiner Southern Md.</u>			
DATE SIGNED <u>4/11/55</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>4/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Apr. 12-1955</u>		REGISTRAR'S SIGNATURE <u>L. M. Pappas</u>		24. FUNERAL DIRECTOR <u>J. E. Boulais</u>		ADDRESS <u>Greensboro, Md.</u>	

RECEIVED

APR 19 1965

BUREAU V. S.

3524

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Denton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Ind.</u>			
3. NAME OF DECEASED: (First) <u>ANNA</u> (Middle) <u>J.</u> (Last) <u>NORRIS</u>				4. DATE OF DEATH: (Month) <u>APR</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>Nov. 16, 1877</u>		9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Wright</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>-</u>		17. INFORMANT & ADDRESS: <u>hus. Norris Denton Ind.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>422.1 Immediate cause (a) <u>Cerebral Hemorrhage</u></p> <p>Antecedent causes (s) DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)</p>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 22, 1955</u> , to <u>Apr. 22, 1955</u> , that I last saw the deceased alive on <u>Apr. 22, 1955</u> , and that death occurred at <u>Denton, Ind.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Hines</u>		(Degree or title)		ADDRESS <u>Denton, Ind.</u>		DATE SIGNED <u>Apr 23 1955</u>	
23. BURIAL, CREMATION, REINOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr. 25, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Ind.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/26/55</u>		REGISTRAR'S SIGNATURE <u>Wm. D. George</u>		24. FUNERAL DIRECTOR <u>J. Virgil Henshaw</u>		ADDRESS <u>Denton, Ind.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 26 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3525

03513

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Caroline		MARYLAND		STATE Florida		COUNTY Duval	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN Federalburg - Rural		11 months		TOWN Jacksonville 49X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near Friendship				STREET ADDRESS (If rural, give location) ✓			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) William		(Middle) Andrew		(Last) Norris		(Month) April (Day) 9 (Year) 19 55	
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Colored		Married		January 7, 1917	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Day Laborer		Farm and Factory		Jacksonville, Florida		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William Norris				Caretha Kitchen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
Yes		WW II		261-12-5766			
				Claretha M. Norris, Federalburg, Md., R.F.D.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
825X Immediate cause (a) Fractured Cervical Vertebra DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						few months	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Automobile accident							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Lauron D. George				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. 4/9/55			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		April 16, 1955		Jacksonville		Jacksonville, Florida	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
April 11, 1955		Margaret N. Frampton		J.J. Frampton and Son, Federalburg, Md.			

BUREAU V. S.

APR 31 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03514

3526

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u>	(First) <u>Philp</u>	(Middle)	(Last)
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6/8/1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>62</u> yrs. If under 1 year Months. If under 24 hrs. Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Scotland</u> ✓	
13. FATHER'S NAME <u>John Philp</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sim</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>208-05-7018</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Philp Preston, Maryland</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.0 Acute Cardiac Decompensation.</u>		(a)	<u>3 days</u>
Antecedent cause(s) <u>Arteriosclerotic Heart Disease.</u>		(b)	<u>10 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Multiple Myeloma Hypertensive Blood</u>		(c)	<u>6 yrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/12, 1952, to 4/5, 1955, that I last saw the deceased alive on 4/5, 1953, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	DATE <u>4/9/55</u>	NAME OF CEMETERY OR CREMATORY <u>J. O. U. A. M.</u>	LOCATION (City, town, or county) (State) <u>Preston Maryland</u>
DATE REC'D BY LOCAL REG. <u>4-7-55</u>	REGISTRAR'S SIGNATURE <u>Cornelia D. Plummer</u>	24. FUNERAL DIRECTOR <u>H. M. Hollis</u>	ADDRESS <u>Preston, Maryland</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3527

CERTIFICATE OF DEATH

Reg. Dist. No. 62

03515

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Caroline</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Caroline</i>	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>X Denton</i>		<i>35 yrs</i>		<i>Denton</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>JOHN ALBERT SEESE</i>				<i>APR 1 1955</i>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
<i>M</i>	<i>W</i>	<i>married</i>	<i>APR. 12, 1878</i>	<i>76</i>			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Carpenter</i>		<i>Building</i>		<i>Pennsylvania</i>		<i>USA</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>Ephraim Seese</i>				<i>Lucinda Wertz</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<i>no</i>				<i>Mrs. Albert Seese, Denton, Md.</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
<i>420.1</i>				<i>Coronary Thrombosis</i>			
Immediate cause (a) DUE TO				<i>Coronary arterio sclerosis</i>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO				<i>4 mo.</i>			
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
		m.					
22. I hereby certify that I attended the deceased from <i>June 28</i> , 19 <i>30</i> , to <i>April 1</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Feb. 19</i> , 19 <i>55</i> , and that death occurred at <i>6 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<i>Paul Burks M.D.</i>				<i>Denton Md</i>		<i>4-2-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Apr. 4, 1955</i>		<i>Denton</i>		<i>Denton, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>4-4-55</i>		<i>Dr. D. O. George</i>		<i>J. Virgil Woods</i>		<i>Denton</i>	

BUREAU V. S.

APR 11 1951

RECEIVED